Barton Creek
Chiropractic + Functional Nutrition
Serious pain relief, naturally.

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1. Please enter your information.

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Social Security #: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

Race (Please check all that apply):
☐ Caucasian ☐ Asian ☐ Black ☐ Native American /Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other :

If other, specify: _____

Would you like to join our e-newsletter?
○ Yes ○ No

Preferred Language:
○ English ○ Spanish ○ Other :

If other, specify: _____

2. Who referred you?

_____

3. Emergency Contact Information

Name: _____ Relationship: _____ Phone Number: _____

4. Do you have Medical Insurance?

○ Private
○ Medicare
○ Medicaid
○ None

5. Primary Insurance

Primary Insurance Company _____ Member ID / Policy # _____ Group Number _____

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name	Insured Phone #	Insured Date of Birth	Insured Gender ○ Female ○ Male

Insured Street Address	Insured City	Insured State	Zip Code

6. Secondary Insurance

Secondary Insurance Company	Member ID / Policy #	Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name	Insured Phone #	Insured Date of Birth	Insured Gender ○ Female ○ Male

Insured Street Address	Insured City	Insured State	Zip Code

7. Is your Insurance through your work?
○ Yes ○ No

Workers Compensation Claim?
○ Yes ○ No

8. Is your current medical condition related to:

○ Personal injury
○ Car accident
○ Worker's compensation

9. What brings you in today?

_____

_____

_____

_____

10. Any inciting injury or trauma?

Date of trauma:

Anything make it worse?

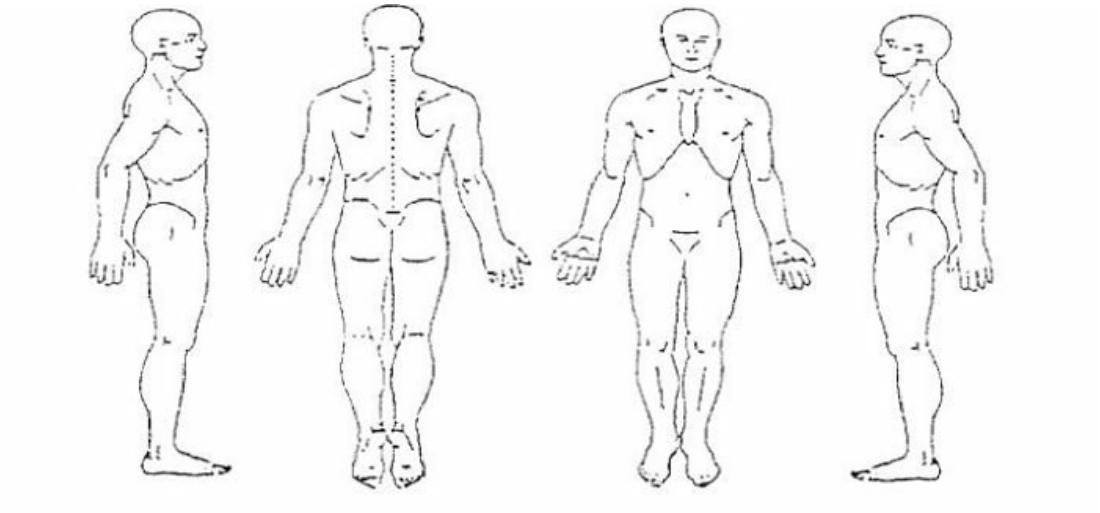
Is the problem worse:
○ Morning ○ Evening ○ with Activity ○ at Rest

11. Is this problem affecting your daily life, work or sleep?

○ Yes
○ No

12. If yes, please explain:

13. Please draw where you feel pain on the image below:



14. Do you experience:

- ☐ Muscle Cramps/Pain
- ☐ Joint Pain/Swelling
- ☐ Numbness/Tingling
- ☐ Stiffness

How severe is your pain:

Are your symptoms:

- ○ Improving
- ○ Worsening
- ○ Stable

15. Have you been treated for this problem before?

- ○ Yes
- ○ No

16. If yes, have you been treated with:

- ☐ Physical Therapy
- ☐ Surgery
- ☐ Chiropractor
- ☐ Exercise Routine
- ☐ Pilates
- ☐ Trigger Point Injection
- ☐ Medications
- ☐ Other:

If other, please specify:

17. Have you undergone any special tests for this condition (i.e. MRI, Xrays?)

- ○ Yes
- ○ No

18. If yes, please explain (include diagnosis and date):

MEDICAL HISTORY

19. How would you rate your overall health?
○ Excellent ○ Good ○ Fair ○ Poor

How would you rate your stress level?

How would you rate your overall energy?

20. List any major injuries:

- ☐ Back
- ☐ Neck
- ☐ Head
- ☐ Broken bones/fractures
- ☐ Severe fall
- ☐ Disability
- ☐ Car Accident
- ☐ Other:

If other, please specify:

21. Please explain any medication injuries checked above:

22. Do you use any assistive devices:

- ☐ Wheelchair
- ☐ Cane
- ☐ Orthotics
- ☐ Other:

If other, please specify:

23. Have you had any Past surgeries?

- ○ Yes
- ○ No

24. If yes, please list past surgeries, year of surgery, and any important notes related to the surgery:

	Type of Surgery	Year	Notes/Comments
1			
2			
3			

25. Are you up to date with vaccinations and preventative health screenings?

- ○ Yes
- ○ No

26. If no, please list:

_____

_____

_____

_____

27. Medical History (Check all that apply)

- ☐ Heart Disease
- ☐ Stroke/TIA
- ☐ Pacemaker
- ☐ High Blood pressure
- ☐ Glaucoma
- ☐ Hearing Impairment
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Lung Disease
- ☐ Sleep Apnea
- ☐ Skin disorder
- ☐ Scoliosis
- ☐ Arthritis
- ☐ Vertigo
- ☐ Thyroid disease
- ☐ Multiple Sclerosis
- ☐ Other Eye problems
- ☐ Osteoporosis
- ☐ Depression/Anxiety
- ☐ Seizures/Epilepsy
- ☐ Liver disease
- ☐ Dementia
- ☐ Low Blood Pressure
- ☐ Multiple sclerosis
- ☐ Bleeding disorder
- ☐ Colitis/Chron's disease
- ☐ Diabetes Type I or II
- ☐ Lupus erythema
- ☐ Cataracts
- ☐ Cancer
- ☐ Alcohol/Substance Abuse
- ☐ Muscle disorders
- ☐ Fibromyalgia
- ☐ Kidney Disease/Failure
- ☐ STDs
- ☐ Other:

If other, please specify:

_____

REVIEW OF SYMPTOMS

In the following section, please check any symptoms that you currently experience.

28. General

- ☐ Fatigue
- ☐ Frequent Infections
- ☐ Heat or cold intolerance
- ☐ Unexplained weight loss or gain
- ☐ Difficulty with Balance
- ☐ Hot Flashes/Cold Sweats

29. Eyes

- ☐ Vision problems
- ☐ Sensitivity to Light
- ☐ Red/Dry/Itchy Eyes

30. Ear, Nose, Throat

- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Nose Bleeds
- ☐ Loss of Smell
- ☐ Sinus Congestion
- ☐ Ringing/Buzzing in the Ears

31. Neurologic/Psychological

- ☐ Anxiety
- ☐ Depressed Mood
- ☐ Dizziness/Lightheadedness
- ☐ Facial Weakness
- ☐ Memory Problems
- ☐ Sleeping Problems
- ☐ Headaches
- ☐ Slurred speech
- ☐ Numbness/tingling

32. Gastrointestinal

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Loss of bowel control

33. Respiratory

- ☐ Bloody cough
- ☐ Snoring
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Excess sputum/mucus

34. Cardiovascular

- ☐ Ankle swelling
- ☐ Chest pain
- ☐ Leg pain when walking
- ☐ Difficulty walking a block
- ☐ Difficulty breathing while lying flat

35. Skin/Muscles

- ☐ Easy bruising/bleeding
- ☐ Joint pain/swelling
- ☐ Nail changes
- ☐ Muscle weakness
- ☐ Dry, itchy skin
- ☐ Skin rashes/hives

36. **Do you/Have you:**

	Yes	No	If Yes, Explain:
Have a history of weak bones (osteoporosis or osteopenia?)	Yes	No	
Have numbness/tingling or weakness in the arm or leg?	Yes	No	
Been diagnosed with cancer in the spine?	Yes	No	
Have an increased risk for having a stroke?	Yes	No	
Have any bone abnormality in your neck?	Yes	No	
Had sudden numbness in the groin region or loss of bowel or urine control?	Yes	No	

Medications

37. **List all medications you are taking, including any over-the-counter medications, herbs or vitamins:**

	Name	Dosage	Frequency	Reason for Taking?
1				
2				
3				

38. **Are you taking any:**

Blood thinning medication?
○ Yes ○ No

Steroid medication?
○ Yes ○ No

39. **Do you have any allergies?**

○ Yes
○ No

40. **If yes, please list:**

	Allergic to?	Reaction
1		
2		

SOCIAL HISTORY

41. Do you:

	Yes/No/Past	If yes, How Much?	How Often?
Smoke?			
Drink alcohol?			
Drink caffeine?			
Use pain medications?			
Use recreational drugs?			

42. How many times a week do you exercise for 30 minutes or more:

43. What do you do for work?

Is there significant stress in your job?
○ Yes ○ No

If yes, explain:

Does your job consist mostly of:
☐ Sitting ☐ Computer Work ☐ Standing
☐ Heavy lifting ☐ Other:

If other, please specify:

44. Female Only

Menopause?
○ Yes ○ No

Hormone replacement?
○ Yes ○ No

Are you pregnant?
○ Yes ○ No

Trying to get pregnant?
○ Yes ○ No

#Pregnancies: # Live Births: #Abortions: #Miscarriages:

Do you have:
☐ Irregular Periods ☐ Cramps ☐ Abnormal Bleeding ☐ Breast Pain ☐ UTI ☐ Urine Incontinence

45. Male Only

Do you have:
☐ Erection Problems ☐ Urinary Problems ☐ Prostate Problems ☐ Testicular/Scrotal Pain

FAMILY HISTORY

46. Please list if each of the following family members are alive, current age (or age at time of death), and any health concerns/problems they experienced:

	Age	Alive?	Health Concerns
Paternal Grandfather			
Paternal Grandmother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Mother			
Brother (s)			
Sister (s)			